PA-1
(R. 10-82)

APPLICATION FOR AFDC OR AFDC RELATED MA

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

1. County and Case No. _____

2. Date _____

3. Applicant Name _____
(Last) (First) (M . I .)

4. Mailing Address _____ 5. Phone _____ [ ]Applicant [ ]Other
(Street, P.O. Box, etc.) (City) (State) (Zip Code)

6. Residence (if different from mailing address) _____

7. Directions to Residence _____

a. Have you or anyone else in this application previously applied for or received assistance? []Yes[]No If yes, Who? _____

Where? _____ When? _____ Case Number? _____

9a. This is an application for: [ ]AFDC[]AFDC RELATED MA b. Type of Application: []New[ ]Reapplication (Use old case number.)

c. Other Program Status: [ ]AFDC [ ]MA: Case Name(s) and Number(s) _____

[ ]Food Stamps: Case Name and Number _____

10a. If you are not receiving Food Stamps, have you applied? [ ]Yes Date [_____]No b. Are you interested in applying? []Yes[]No

11. Persons for Whom Assistance is Requested

					AGENCY USE ONLY					
a. Name (Last) (First) (M.I.)	b. Depr.	c. Race	d. Sex	e. Citizen/ Alien No.	f. DOB	g. Ver.	h. Marriage/ Relation	i. SSAN	j. Rec. AFDC in Last 4 Months	k. Med. Exp. in Last 3 Months
SR							Self		Yes No	Yes No
SP									Yes No	Yes' No
Children									You No	Yes No
									Yes No	Yes No
									Yes No	Yes No
									Yes No	Yes No
									Yes No	Yes No
									Yes No	Yes No

12. I hereby make application for a money payment and or medical assistance. I agree to give the Department for Social Insurance any information necessary to establish my eligibility. I understand furnishing Social Security Numbers for all persons for whom application is made is required in order to receive AFDC. I understand if I'receive too much money, for whatever reason, I will be required to repay it. I understand in accepting AFDC, I assign all past, current and future child support for children for whom I receive AFDC to the Department for Social Insurance. I understand if I am applying for AFDC or Medical Assistance for myself, or for child(ren) as a parent or legal guardian, I am assigning my rights for third party payments and am willing to cooperate with the Department for Social Insurance. I certify, under penalty of perjury, the information provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify my statements. I understand if I give false information, withhold information or fail to report changes within 10 days, I may be subject to prosecution for fraud.

13. Signature of Applicant _____ Date _____ If signed by mark:

Signature of Worker _____ Date _____ Signature of Witness _____ Date

YOURRIGHTS

As an applicant you have certain rights. These are:

1. The right to prompt action on your case.
2. The right to have your case treated confidentially.
3. The right to receive a money payment and or medical assistance if it is determined that you meet all eligibility requirements.
4. If you are eligible for a money payment, the right to spend it any way you wish.
5. The right to a hearing before an impartial hearing officer if you are dissatisfied with any action or inaction of the Department. If your complaint involves alleged discrimination due .to race, color or national origin, you have the right to appeal directly to the Secretary of Health and Human Services, Washington, D.C., if you prefer.

CIVIL RIGHTS

The Programs of the Department for Social Insurance are administered in such a manner that no person will, on the grounds of color or national origin, be excluded from any benefits under the program or otherwise be subjected to any discrimination.

YOUR OBLIGATIONS

Give the worker complete and accurate information, substantiated by documents as requested on:

1. Any factor of technical eligibility, including proof as appropriate, that the parent of the child(ren) is out of the home.
2. Income, including wage stubs, award letters, etc., for yourself, spouse, children, and other household members such as alien sponsors and parents of minor parents.
3. Resources.
4. Your marital status.
5. Your living arrangements.
6. Any other fact that has any bearing on your eligibility, including medical reports of physical or mental examinations to determine the existence or degree of incapacity including submission to additional examinations when indicated.

Keep any appointment to see your worker or give advance notice if the date or hour is unsatisfactory to you.

If your application is approved, inform the Department within 10 days of any changes in your circumstances affecting your eligibility or amount of payment. Failure to do so may result in a loss of benefits and or in prosecution for fraud.

During your interview, your worker will assist you in applying for a Social Security number for anyone for whom you request assistance who does not already have a Social Security Card. The Social Security Act requires that all recipients of money payments must be identified by such a number. The Department shall not make a payment for any individual who refuses to apply for a number. If you are applying for Medical Assistance only, the Department will also need a Social Security *number* for identification purposes. The information you provide in order to obtain a number and the number when received, will be used only for purposes of administering the program of the Cabinet for Human Resources, and will be disclosed by the Cabinet or the Social Security Administration only as permitted by law.

— AGENCY USE ONLY —

PA- IA
(R. 3/91)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
Department for Social Insurance

1. Date _____
Place: [ ]Home [ ]Office [ ]Facility

2. SSI Status:
[ ]Receiving
[ ]Denied/Disc. _____
[ ]Reason _____
[ ]Pending _____
[ ]Never Applied

Medical Assistance/Supplementation
Application/Eligibility Determination
Aged, Blind, and Disabled

Case No. _____
(Co.) (Prg.) (SSN)

[ ]New Application [ ]Investigation
[ ]Reinvestigation [ ]Previously Received
[ ]Reinstate within 10 days of Disc.

3. Name _____ / / (Birth Date)
(Last) (First) (MI)
[ ]Home
[ ]Facility Address: _____
(Street or RFD) (City) (State) (Zip Code) (Telephone)

Race: [ ]White [ ]Black [ ]Other _____ Sex: [ ]Male [ ]Female

SSN _____ [ ]Verification Attached Claim No. _____ [ ]Verification Attached

4. Marital status: [ ]Single; Nwcr Harried [ ]Divorced; Date _____ [ ]Widowed; Date _____
[ ] Married; Living Together [ ]Married; Living *Apart Since* Date _____

Citizenship/Alien Status - Citizen or national of the United States [ ]Yes [ ]No
If no: In satisfactory Migration status? [ ]Yes [ ]No Immigration and Naturalization Service (INS) Status _____

Name of Spouse or Parent of Disabled Child _____ / / (Birth Date)
(Last) (First) (MI)

SSN _____ Claim No. _____

[ ]Home [ ]Facility Address if living apart: _____

Spouse is: [ ]SSI [ ]MA Only [ ]SSP [ ]AFDC [ ]Ineligible Dependents _____
Parent of Disabled Child is: [ ]SSI [ ]MA Only [ ]SSP [ ]AFDC [ ]Ineligible Dependents of Parent _____

ALL CASES

	TECHNICAL ELIGIBILITY	Requirement Bet
5. Basis of Eligibility [ ]Age [ ]Blind [ ]Disabled [ ]SSI-ABD	Age verified by: _____ Basis for Field Determination: _____ Blind or Disabled (PA-610) Onset Date: _____	[ ] Yes [ ] No
6. In LTC. PST/MI, HCBS, AIS/MR, Hospice, PCH, FCH, I]Yes [1 No	Name of Facility: _____ [ ]Public [ ]Private; [ ]LTC [ ]PSY/MH [ ]HCBS [ ]AIS/MR [ ]Hospice [ ]PCH [ ]FCH; [ ]Licensed [ ]Unlicensed	[1 Yes [ ] No
7. Residence	Residence Verification	[ ] Yes [ ] No

8. Caretaker:
Name, Address, Telephone No. _____

Name, Address, Telephone No. _____

Services Provided to: [ ]Client [ ]1 of an Elig. Couple [ ]Elig. Couple Services Provided Prevent Institutionalization? [ ]Yes [ ]No

Services Purchased: _____

Purchase Verified By: _____

P5 6 or

FINANCIAL ELIGIBILITY

9. Resources [ ]Client [ ]Client and Spouse [ ]Client and Dependent(s) [ ]Client and Parent(s)

a. Real Property	Assessed	Debt	Equity	Type. Location, Verification, Computation	Amount Considered
Disposal of Real Property [ ]Yes [ ]No	$	$	$		
Home Property [ ]Yes [ ]No	$	$	$		
Non-home Property Income Producing [ ]Yes [ ]No	$	$	$		
Non-Income Producing [ ]Yes [ ]No	$	$	$		
b. Motor Vehicle(s) [ ]Yes [ ]No	IADA/FMV $	$	$	Verification Attached []	

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9. Resources (cont'd) [ ]Client [ ]Client and Spouse [ ]Client and Dependent(s) [ ]Client and Parent(s)

c. Burial/Life Ins.	Ins. Co./Policy No. and FV/CSV and/or Funeral Home/Address/Amount	Amount Considered
Life Insurance [ ]Yes [ ]No		
Other Burial Reserves [ ]Yes [ ]No		
	Verification Attached [ ]	

d. Liquid Assets	Amount	Location, Account Number, Verification	
Transfer of Liquid Assets [ ]Yes [ ]No	$		
Cash [ ]Yes [ ]No	$		
'Checking Acct. [ ]Yes [ ]No	$		
Savings Acct. [ ]Yes [ ]No	$		
Stocks/Bonds [ ]Yes [ ]No	$		Countable Resources 9a.....$ 9b.....$ 9c.....$ 9d.....$ TOTAL..$
Trusts [ ]Yes [ ]No	$		
Cert. of Dep. [ ]Yes [ ]No	$		
Other [ ]Yes [ ]No	$	Verification Attached [ ]	Within Limits? [ ]Yes [ ]No

10. Income — Computation/Verification/Amount Considered

	Amount Received By: Client	spouse	Parent	Dependents
Earned				
Wages.....	$	$	$	$
Farm/ Business....	$	$	$	$
Rental.....	$	$	$	$
Other Self-Employment..	$	$	$	$
Other.....	$	$	$	$
Unearned				
Farm/ Business....	$	$	$	$
Rental.....	$	$	$	$
SSI.....	$	$	$	$
RSDI.....	$	$	$	$
Black Lung..	$	$	$	$
RR.....	$	$	$	$
VA.....	$	$	$	$
Pension.....	$	$	$	$
Other.....	$	$	$	$

Verification Attached, [ ]

11. Medical Expenses Use item 13 for listing recognized medical expense(s) considered.

a. Health Insurance [ ]SMI $_____ [] HIB (Client) List all other health insurance of client and
[ ]SMI $_____ [] HIB (Spouse) spouse and dependent children, if applicable.

List all other health insurance policies, coverage and premiums of client and spouse/dependent children. Indicate individual(s) covered, how often premiums are paid and who pays the premium.

b. List Other Medical Expenses.

12. I certify all entries have been read by me or to me and are correct and true to the best of my knowledge and belief I declare, under penalty of perjury, that I am a U.S. citizen or admitted under an approved alien status. I understand information on this application is used to determine if I am eligible for benefits from the Department for Social Insurance. I understand if I receive Medical Assistance I assign the rights to third party payments and am willing to cooperate with the Cabinet for Human Resources, Department for Social Insurance. I understand if I givt false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I have also read, or had read to me, the explanation of my rights and obligations as a Social Insurance client and understand I have the right to request a Fair Bearing before an impartial hearing officer if I am dissatisfied vith any agency action. I further give my consent to the Department for Social Insurance to make any necessary contacts to verify my statement or gain additional information pertinent to my eligibility.

I understand that Social Security numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, wage records, unemployment insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification. may affect eligibility for and amount of benefits. This information will he disclosed to other agencies only as permitted by law.

(Signature of Committee, Representative, Client or Witness if Signed by mark) (Date Signed) (Phone No. - Com./Rep.)

Address

13. INCOME ELIGIBILITT COHPDTATIONS

a. Spend Down/Regular MA

1. Quarters Considered..	____ to ____	____ to ____
2. Family Size.....		
3. Countable Income....	$	$
4. Leas HA Scale.....	$-	$-
5. Monthly Excess.....	$	
	X3	X3
6. Quarterly Excess....	$	$
7. Less Recognized Medical Expenses....	$-	$-
a. Excess or "0".....	$	

b. State Supplementation Payment (SSP)

1. Standard.....	
2. Less Countable Income.....	
3. Payment-Single Individual or Elig. Individual with Inelig. Spouse OR Eligible Couple One Requiring Care..	
4. 1/2 of #3 for Eligible Couple Both Requiring Care (Caretaker Services Only).....	$

Recognized Medical Expenses

Date of Service	Type of Bill and Verification	Amt. of Recognized Medical Expense

TOTAL Recognized Medical Expenses Considered..... $

Pass Through [ ]Yes [ ]No If Yes, complete form PA-1A, Supplememnt A.

d. Companion Case [ ]Yes [ ]No If Yes, complete form PA-1B.

(Case Name) (Case Number) (Case Name) (Case Numbe:

CASE

JKM

BD-FGH

13. INCOME ELIGIBILITY COMPUTATIONS (continued)

e. Long Term Care

Step I

Complete if Client Has Been in LTC 30 Full Consecutive Days.

1. Client's Gross Income ..... $_____
2. Special Income Standard (3 x SSI Rate)..... $- _____
3. No Excess, Complete Step III. Excess, Complete Step II ..... $= _____

Step II

Complete if Client Has Been iu LTC Less than 30 Full Consecutive Days.

1. Client's Countable Income (Gross Income/Net Profit Less $20 General Exclusion).. $_____
2. Plus Spouse's Gross Income/ Net Profit if Spouse's Income Exceeds the Special Income Standard for an Individual, if appropriate..... $+ _____
   $= _____
3. Less HA Scale for 1 (or 2 if Spouse's Income is Considered)..... $- _____
   $= _____
4. Less Client's Recognized Medical Expenses..... _____
   $= _____
5. Less Spouse's Recognized Medical Expenses (if spouse's income is considered)..... _____
   $= _____
6. Less Mo. LTC Private Pay or Hospice Institutional Rate or Ester Cost of HCBS (Form MAP-9) or AIS/MR (Standard).. $- _____
7. No Excess, Complete Step III. $= _____

Step III

1. Client's Gross Income/Pet Profit. $_____
2. Plus Spouse's Excess Income When Appropriate (Gross Income/ Net Profit Less MA Scale for I).. $+ _____
   $= _____
3. Less Personal Needs Allowance.... $- _____
   $= _____
4. 'Less Increased Personal Needs Allowance..... $- _____
   $= _____
5. Conserved for Spouse and/ or Dependent(s) up to HA Scale for Family Size..... $- _____
   $= _____
6. Less LTC Client's Recognized Medical Expenses..... $- _____
   $= _____
7. Less Spouse's Recognized Medical Expenses..... $- _____
   $= _____

a. Plus VA Aid and Attendance Allowance..... $+ _____

9. Client's Liability..... $= _____

14. CASE DECISION

a. State Supplementation (SSP)

1. [ ]Approved [ ]Continued Eligible
2. MA Eff. Date _____ *
   Grant $ _____ Eff. Date _____

c. Denied/Discontinued

1. [ ]Denied/WD (Reason) _____
2. [ ]Denied, Code 2, Excess Inc., Qtr. $ _____
3. [ ]Discontinued (Reason) _____

b. Medical Assistance (MA)

1. [ ]Approved, Code 1, Eff. MA Date _____ *
   [ ]Approved, Code 7, Eff. MA Date _____ *
2. [ ]Approved, Code 2, From _____ To _____
   From _____ To _____
3. [ ]Approved, Code 3, Eff. MA Date _____ *
4. [ ]Approved, Code 5, Eff. MA Date _____ *
5. [ ]Continued Eligible

ALL CASES

15. Standard of Promptness net? [ ]Yes [ ]No If No, Reason _____
16. Spot Check Alert? [ ]Yes [ ]No Reason _____ Date _____
17. *If Less Than 3 Months Retroactive Coverage, Explain _____
18. Worker's Signature _____ Date _____

Concurred by _____ Title _____ Date _____

PA-1C
(R. 10/91)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

FOR AGENCY USE ONLY

Case Number _____

[ ] Investigation [ ] Office Visit
[ ] Reinvestigation [ ] Home Visit

Date Issued _____ Date Received _____

STATEMENT OF NEED

The following information is needed by the Kentucky Department for Social Insurance to make a decision about a monthly check or help with medical bills. It is important that this form be completed very carefully. ***Information must be true.*** *False statements make you subject to prosecution for fraud.* ***Bring the completed*** *form with you when you come in for your appointment.*

ALIENS ONLY. *If you are an alien, and made your first application for assistance on or after October 1, 1981, both you and your private sponsor must answer all questions. Attach a separate sheet of paper with your private sponsor's signed and dated report of his or her own circumstances.*

IF ADDITIONAL SPACE IS NEEDED TO ANSWER ANY QUESTIONS, ATTACH A SEPARATE SHEET OF PAPER.

1. Name _____ (First) (Middle Initial) (Last)

White, not of Hispanic origin [ ] Hispanic [ ]
Black, not of Hispanic origin [ ] American Indian or
Asian or Pacific Islander [ ] Alaskan Native [ ]

2. Mailing Address _____ (Street, RFD or P.O. Box) (Apt. No.) (City) (State) (Zip Code)

3. Is your mail delivered in care of someone else? Yes [ ] No [ ] If yes, who _____

4. Street Address (if different from mailing address) _____

5. Directions to Home _____

6. County _____ Telephone where you can be reached _____ Yours [ ] Nearby [ ]

7. Are you planning to move? Yes [ ] No [ ] If yes, when? (Date _____

New mailing address _____ (Street, RFD or P.O. Box) (Apt. No.) (City) (State) (Zip Code)

New Street Address (if different from mailing address) _____

8. On the following lines, list all persons living in your home. All columns must be answered for each person.

First Name	Last Name	Social Security Number	Sex M/F	Relation To You	Birthdate Mo/Day/Yr	Does this Person Receive AFDC? (circle one)	Highest School Grade Completed	Complete for All Children 'If school is not in session, base your answers on the child's attendance during last session.			
				Self		Yes No					
				Spouse		Yes No		Attending School Regularly •	Name and Address of School	Type of School	Expected Date of Comoletion
						Yes No		Yes No			
						Yes No		Yes No			
						Yes No		Yes No			
						Yes No		Yes No			
						Yes No		Yes No			
						Yes No		Yes No			
						Yes No		Yes No			
						Yes No		Yes No			

9. Are you or anyone living in Your home pregnant? Yes [I No [ ]

Name _____ Expected Delivery Date _____

Name _____ Expected Delivery Date _____

10. Is anyone in your home receiving Food Stamps7 Yes [I No [ ] If yes, names _____

11. Complete the questions below for each person under age 19 for whom you want to receive assistance.

Child's Name	Name of Parent	Is Parent in Home? (circle one)	Is Parent Disabled? (circle one)	Is Parent Unemployed? (circle one)	Is Parent Deceased? (circle one)	Is Parent In Hospital or Prison? (circle one)	Absent Parent's Address	Date Parent Left Home
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Father:	Yes No	Yes No	Yes No	Yes No	Yes No		
	Mother:	Yes No	Yes No	Yes No	Yes No	Yes No		

Answer the following questions with complete information about your resources.

12. Do you, your spouse, or children own or are any of you buying the home in which you live? Yes [ ] No [ ]

13. Do you, your spouse, or children own or have an interest in real property (land or buildings) other than where you live? Yes [ ] No [ ] If yes, complete the following:

Type of Property	Assessed Value	Amount Owed	Income from Property	Monthly	Yearly	Who receives this income?	Is property for sale?
	$	$	$				Yes [ ] No [ ]
	$	$	$				Yes [ ] No [ ]
	$	$	$				Yes [ ] No [ ]

If this property is being offered for sale, bring proof such as a newspaper ad, real estate listing, etc., to your worker with this form.

14. Did you, your spouse, or children buy, trade, sell, or give away any property or assets within the past 24 months?
Yes [ ] No [ ] If yes, complete information below:

Type of Asset or Property Bought, Traded, Sold, or Given Away	Date of Transfer - - Assessed Value	Who Received this Property	Amount Owed on Property Transferred	Cost of Transferring	Amount Paid or Received
	$		$	$	$
	$		$	$	$

You will be expected to provide documents to verify the transfer of any property or assets listed.

15. Circle either "yes" or "no" if you, your spouse, or children have any of the following assets. If "yes", complete the remaining columns. Under "other items", list items worth more than $50, such as, jewelry, burial plots, tools, etc. You will be expected to provide verification of any assets listed.

Type of Money or Savings	Circle One	Amount	Name of Bank or Location of Savings	Who has this?
Checking Account	Yes No	$		
Savings Account	Yes No	$		
Certificates of Deposit, Stocks, Savings Bonds, or Other Bonds	Yes No	$		
Other Cash Not Listed Above	Yes No	$		
'Other Savings or Trust Funds	Yes No	$		
Other items: _____	Yes No	$		
Other items: _____	Yes No	$		
Other items: _____	Yes No	$		

• Explain O avings or Trust Funds

16. Do you, your spouse, or children own or are you buying a motor vehicle? Yes [ ] No [ ]
If yes, complete the following:

Owner's Name	Type (Car, Truck, Boat, Camper, etc.)	Year	Make (Ford, GMC, etc.)	Model (Escort, ½ ton, etc.)	Body Style (2-dr. sedan, pickup, etc.)	Value / Amount Owed
						$ / $
						$ / $
						$ / $

Is any vehicle listed used to obtain medical treatment? Yes [ ] No [ ]

Is any vehicle listed specifically equipped for use by a handicapped household member? Yes [ ] No [ ]

Is any vehicle listed used for self-employment? Yes [ ] No [ ]

17. Is anyone awaiting settlement from an accident? Yes [ ] No [ ] If no, skip to item 18. If yes, complete the following:

a. Date of accident _____ b. Person involved _____

c. Type of accident:

[ ] Employment Related

Employer's Name and Address _____

Have you applied for Workmen's Compensation? Yes [ ] No [ ] If yes, when? _____ Where? _____

[ ] Automobile

Your Insurance Company Name and Address _____ Policy No. _____

Other Party's insurance Company Name and Address _____ Policy No. _____

Other Party's Name and Address _____

18. Do you] your spouse, or children own or are you covered by burial or life insurance policies? Yes [ ] No [ ]

Do you, your spouse, or children have a prepaid burial fund? Yes [ ] No [ ] If yes to either question, complete the following:

Owner of Policy or Fund	Persons Covered	Name of Bank, Funeral Home or Insurance Co.	Policy No. and Face Value	Value if Cashed In and Amount of Loan Against Policy	Amount of Fund
			$	$	
			$	$	$
			$	$	
			$	8	$
			$	$	
			$	$	$

You will be expected to present verification of any policies or funds listed.

19. Are you, your spouse, or children covered by any of the following types of hospital or health insurance?
Insurance Types and Letter Codes:

Yes No
[ ] [ ] None. If "Yes", skip to item 20 .... .M
[ ] [ ] Part A Medicare Only ..... .A
[ ] [ ] Part B Medicare Only. ..... .B
[ ] [ ] Both Parts A and B Medicare..... C
[ ] [ ] Blue Cross/Blue Shield. ..... D

Yes No
[ ] [ ] Blue Cross/Blue Shield - Major Medical ..... E
[ ] [ ] Private Medical Insurance Specify _____ ...F
[ ] [ ] Champus ..... G

Yes No
[ ] [ ] Health Maintenance (HMO) ..... H
[ ] [ ] Absent Parent's Insurance L
[ ] [ ] United Mine Workers ..... N
[ ] [ ] Black Lung ..... P
[ ] [ ] Other ..... J

If yes to any of the above, complete the following. Enter the appropriate letter code to indicate type of insurance and complete all remaining columns. Bring policy to your worker.

Name and Address of Insurance Company or HMO	Type (Letter Code)	Policy Number / Name of Insurance Agency	Amt. of Mo. Payment	Who pays this premium?	Name of Persons Covered by Policy
			$		
			$		
			$		
			$		

20. Have you or your family received any medical bills in the last 3 months? Yes [ ] No [ ]
If yes, bring these bills to your worker with this form.

The following sections relate to income and must be completed for you, your children, spouse and parent living in the home. You must indicate either "yes" or "no" for each type of income shown. You will be expected to present verification of income. Verification may be actual checks, wage stubs, award letters, etc. If you are an alien, information is also required regarding income of your sponsor.

21. Does any person in your home have any of the following types of unearned income?

income Types and Letter Codes:

Yes	No		
[ ]	[ ]	Social Security (Green Check)	A.
[ ]	[ ]	Supplemental Security Income (Gold Check)	B
[ ]	[ ]	Veteran's Benefits.	C
[ ]	[ ]	Railroad Retirement	D
[ ]	[ ]	Unemployment insurance	E
[ ]	[ ]	Military Allotment	F
[ ]	[ ]	Workman's Compensation.	G
[ ]	[ ]	Black Lung Benefits	H

Yes	No		
[ ]	[ ]	Oil, Gas, Coal or Other Leases, or Mineral Rights	I
[ ]	[ ]	Cash Rent From Land	J
[ ]	[ ]	Rental or Lease Income (Including Farm Land or Crops)	K
[ ]	[ ]	Money From Friends or Relatives (including Contributions or Cash Gifts)	L
[ ]	[ ]	Other (Specify) _____	M

if yes to any of the above, enter the name of each person receiving income Enter the appropriate letter code to indicate the type of income received, and complete ail remaining columns.

Person Receiving income	Type of income (Letter Code)	Amount Received Last Month	Amount Received This Month	Amount Expected Next Month	How Often Received (Monthly, Weekly, etc.)
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	
		$	$	$	

22. Have you ever received money from an absent parent? Yes[ ] No[ ] If yes, complete the following to show amounts received this month and the 3 months before this month:

Name of Absent Parent	Names of Children	Amount Received This Month	Amount Received _____, 19___	Amount Received _____, 19___	Amount Received _____, 19___
		$	$	$	$
		$	$	$	$
		$	$	$	$

23. Does anyone pay any bills for you or provide for any of your expenses (e.g., food, clothing, shelter, utilities, etc.)?
Yes [ ] No [ ] If yes, complete the following:

Type of Bill or Expense Provided	Amount Paid	How Often. Paid	Date Last Paid	Who Pays Bill or Provides for this Expense (Name and Address)
	$			
	$			
	$			

24. Are you, your spouse, parents living in your home, and/or children now employed? Yes [ ] No [ ] Have any of you been employed in the past? Yes [ ] No [ ] If yes to either of these questions, complete the following:

Name of Employer or Person for Whom Worked	Person Employed	Working Now? (circle one)	Employed From	Last Date Paid
		Yes No	_____ to _____	
		Yes No	_____ to _____	
		Yes No	_____ to _____	

25. Does any person in your home have any of the following types of earned income?

Income Types and Letter Codes:

Yes No
[ ] [ ] Employment (full-time, part-time, odd-jobs, etc.) ..... A
[ ] [ ] Training Allowances. ..... B

Yes No
[ ] [ ] Roomers or Boarders C
[ ] [ ] Rental Property ..... D

Yes No
[ ] [ ] Farm (crops, produce, tobacco base, livestock, ASCS) .....
[ ] [ ] Other (Specify) .....

if yes to any of the above, enter the name of each Person receiving income. Enter the appropriate letter code to indicate the type of income received, and complete all remainin columns. Under "Gross Earnings" enter the amount of earnings before any deductions are made.

Person Receiving Income	Type of Income (Letter Code)	Gross Earnings Last Month	Gross Earnings This Month	How Often Paid (monthly, weekly, etc.)	Day of Week Paid	Tips Received (circle one)
		$	$			Yes No
		$	$			Yes No
		$	$			Yes No
		$				os No

26. Is there a stepparent in Your home7 Yes [ ] No [ ]

Are you under age 18. and living with Your parent or legal guardian7 Yes [ ] No [ ]

If no to BOTH questions. skip to item 27. If yes to either question complete the following:

a. Does a parent, stepparent or legal guardian with whom you live pay child support for children not in the home?
yes [ ] No [ ] If yes, name of person who pays _____ How much $_____

How often _____

b. Does a parent, stepparent or legal guardian with whom you live pay alimony? Yes [ ] No [ ] If yes, name of person who pays _____

How much? _____ How often _____

c. Does a parent, stepparent or legal guardian with whom you live claim children in your home as dependents for federal income tax purposes? Yes [ ] No [ ] If yes, names

of children claimed _____

_____

d. Does a parent, stepparent or legal guardian with whom you live claim adult relatives in the home, other than you, for federal income tax purposes? Yes [ ] No [ ] If yes.

names of adult relatives claimed _____

_____

27. a. Do you, or a minor parent (parent under age 18) living in your home, attend school or training? Yes [ ] No [ ]
If yes, complete the following:

Name _____ No. of Hours _____ Name and Address of School _____

Name _____ No. of Hours _____ Name and Address of School _____

b. Are you, or a minor parent (parent under age 18) living in your home, employed? Yes [ ] No [ ]
If yes, complete the following:

Name _____ Hours Worked Per Week _____

Name' _____ Hours Worked Per Week _____

c. Do you, or a minor Parent (parent under age 18) in your home, have to pay for care of any child or adult who is unable to work, so that the Person paying may continue to work or attend school7 Yes [ ] No [ ]
If you answered yes, complete the chart below:

Name and Address of Person or Agency Providing Care	Phone Number	Relation to You	Name and Age of Person Receiving Care	Amount Paid	How Often
				$	
				$	

28. Have there been or do you expect any changes in the following areas: Someone starting or quitting work; changing jobs; changing a last name; getting married; starting or quitting school or training? Yes [ ] No [ ] If yes,

Who _____ Change _____ When _____

Who _____ Change _____ When _____

After completing the form. It Is a good idea to read it over to make sure you have answered every question. If you are not sure about some of your answers, talk to Your worker about them. Also, read your appointment letter carefully and bring with you any other papers your worker has requested when you come into the office.

29. I understand that during my interview, my worker will assist me in applying for a Social Security Number for anyone for whom I request assistance who does not already have a Social Security card. The Social Security act requires that all recipients of assistance be identified by such a number. Under that law and federal regulations, the Department cannot make a payment or provide medical assistance for any individual who refuses to apply for a number.

I understand that Social Security numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include. but are not limited to, Social Security, IRS, SSI, wage records, unemployment insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits. This information will be disclosed to other agencies only as permitted by law.

I understand that in accepting Aid to Families with Dependent Children (AFDC), I assign all support rights for children for whom I receive AFDC to the Cabinet for Human Resources, Department for Social Insurance.

I understand that in accepting Medical Assistance, I assign my rights to third party payments from any source, including hospital or health insurance policies. to the Cabinet for Human Resources, Department for Social Insurance. I further understand that if I refuse to assign my rights to third party payments to the Cabinet for Human Resources, Department for Social Insurance, I and the members of my case will be ineligible to receive a check or medical card.

I understand that when I obtain medical services with a Medical Assistance card issued to me I am responsible for notifying the medical provider of any hospital or health insurance policies covering me or any members of my case.

I agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments.

I understand that I, or a member of my case, may be required to participate in the Job Opportunities and Basic Skills (JOBS) Training Program or I, or a member of my case, may volunteer to participate in JOBS at anytime.

I understand that I may receive help in paving certain expenses such as child care and transportation while I am attending a school or training program or while participating in the JOBS program.

30. I certify that the information provided bv me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify statements.

31. I declare under penalty of perjury that all Persons for whom application is made are U.S. citizens or are admitted under an approved alien status.

I understand that if I give false information. withhold information, or fail to report changes within 10 days, I may be, subject to prosecution for fraud.

(Signature) (Date Signed)

(Signature of Spouse1 (Date Signed)

If signed. by mark:

(Signature Worker) (Date Signed)

(Signature of Witness) (Date Signed)

PA-IP
(R. 4/92)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

MEDICAL ASSISTANCE APPLICATION FOR PREGNANT WOMEN AND CHILDREN

AGENCY USE ONLY

1. [ ] Application/Reapplication
   [ ] Reinvestigation [ ] Reinstatement

AGENCY USE ONLY

2. Co./Case Number _____
   Date _____ [ ] Home [ ] Office

COMPLETE THIS APPLICATION ONLY IF A PREGNANT WOMAN OR CHILD LIVES IN THE HOME

SECTION I - APPLICANT INFORMATION

3. Applicant Name _____ [ ] Applicant [ ] Oth
   (Last) (First) (M.I.) (Phone Number)

4. Mailing Address _____
   (Street, P.O. Box, etc.) (City) (State) (Zip Code)

5. Residence (if different from mailing address) _____

6. Directions to Residence _____

7. Have you or anyone else in your household previously applied for/received assistance? [ ] Yes [ ] No
   If yes, who? _____ When? _____ Case Number _____
   Where? _____

8. Other Program Status: [ ] AFDC [ ] MA Case Name(s)/Number(s) _____
   [ ] Food Stamps Case Name/Number _____

9. If not currently receiving Food Stamps, have you applied? [ ] Yes Date _____ [ ] No
   If no, are you interested in applying? [ ] Yes [ ] No

SECTION II - MEMBER INFORMATION (List all household members.)

10. Name (Last) (First) (M.I.)	11. Race	12. Sex	13. Citizen/ Alien Number	14. Date of Birth	15. Marriage/ Relation	16. Social Security Number	17. Grade Level Completed	18. Health Ins. Yes/No	*19. Pregna Yes/N

*If yes, Due Date

20. Has the Pregnant woman and/or child(ren) had medical treatment in the past three months? [ ] Yes [ ] No

SECTION III - FINANCIAL INFORMATION

21. List the gross income (before any deductions) of you, your spouse, and children living with you. If you are under age 21 and live with your parent(s), list parental income. EXAMPLES OF INCOME: wages, salaries, tips, child support, unemployment compensation, Social Security, Veterans benefits, contributions from friends or relatives, interest, etc.

Member	Source	Amount	How Often Received? Member	Source	Amount	How Ofte Received
		$			$	
		$			$	
		$			$	

22. If you are working, amount paid for child care $ _____ wk./mo.

23. If you or Your spouse are not currently employed, complete the following:

Name	Date of Last Employment	Name of Employer	Type of Employmer

I understand that during my interview, my worker will assist me in applying for a Social Security Number for anyone whom I request assistance who does not already have a Social Security card. The Social Security Act requires that a recipients of assistance be identified by such a number. Under that law and federal regulations, the Department ca make a payment or provide medical assistance for any individual who refused to apply for a number.

I understand that Social Security Numbers will be used for various state and federal matches through the Income an Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, Wage records, unemployment insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility and result in termination of benefits. This information will be disclosed to other agencies only as permitted by law.

I understand that in accepting Medical Assistance, I assign my rights to third party payments from any source, including hospital or health insurance policies, to the Cabinet for Human Resources, Department for Social Insurance. I further understand that if I refuse to assign my rights to third party payments to the Cabinet for Human Resources, Department for Social Insurance, I will be ineligible to receive a medical card; however, the other members of my family will remain eligible provided that all other eligibility requirements are met.

I understand that when I obtain medical services with a Medical Assistance card issued to me I am responsible for notifying the medical provider of any hospital or health insurance policies covering me or any members of my case.

I agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments.

I certify that the information provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify statements.

I declare under penalty of perjury that all persons for whom application is made are U.S. citizens or are admitted under an approved alien status.

I understand that if I give false information, withhold information, or fail to report changes within ten (10) days, I may be subject to prosecution for fraud.

If signed by a mark (X):

(Signature) (Date) (Signature of Witness) (Date)

AGENCY USE ONLY

DETERMINATION/REDETERMINATION OF ELIGIBILITY FOR PREGNANT WOMEN AND CHILDREN

Other Payee _____ [ ]Committee [ ]Pr ve
(Name) (Address)

Other Case(s) in Home _____
(C, MA, FS) (Name) (Number) (Name) (Number)

Check of IMS Programs: Concurrent Receipt? [ ]Yes [ ]No If yes, explain _____

Inactive case pulled and old case number used? [ ]Yes [ ]No If no, explain _____

I. TECHNICAL ELIGIBILITY: To determine technical eligibility, evaluate responses to questions 1 thru 19 by completing the following:

Name of Pregnant Women and Children	A. Pregnancy Verified			B. Enumeration Requirement		C. Residence/ Alien Status		REMARKS
	Yes	No	N/A	Yes	No	Yes	No	

IF APPLICATION IS BEING BADE FOR CHILD(REN) DEPRIVED OF PARENTAL SUPPORT DUE TO VOLUNTARY ABSENCE, COMPLETE ITEM D.

D. Medical Support	Yes	No	REMARKS
1. Medical Support Enforcement Rewired? (If no, skip to item 7 ; if yes, complete PA-125 series)			
2. If yes, client cooperating? (If yes to both 1 and 2, skip to section 11.)			
3. If not cooperating, "good cause" claim filed? (Enter date filed-in REMARKS.)			
4. Determination made? (If yes, enter date in REMARKS; if no, explain.)			
5. "Good Cause" exists?			
6. Claim Reviewed: No change.....			
"Good Cause" no longer exists.....			

7. Nonassistance child support services requested?

I. TECHNICAL ELIGIBILITY (continued)

E. Health Insurance Reported?	Yes	No	REMARKS
1. Client questioned?			
2. Statements in doubt or inconsistent?			

(If health insurance initially reported or changed, complete form **PA-40)** .

II. INCOME **ELIGIBILITY** - To determine income eligibility, evaluate responses to question 20 and 21 **by** completing the following:

	Yes	No	REMARKS/COMPUTATIONS
A. UNEARNED INCOME reported?			

If unearned income, complete the following:

Type.	Member(s)	Verification	Amount
			$
			$
			$
			$

	Yes	No
B. EARNED **INCOME** reported?		

If earned income, complete the following:

Type	Member(s)	Verification	Amount
			$
			$
			$
			$

	Yes	No
C. DEPENDENT CARE requested as work expense?		

If yes, enter name/address of provider _____

_____

Phone No. _____ Verified **Amount** $_____

	Yes	No	
D. INCOME DEDUCTIONS appropriate?			
1. **Parent(s)/Child(ren)** standard deduction			$
2. Stepparent standard deduction			$
3. Self employment/farm income allowable costs			$

E. **INCOME** ELIGIBILITY **SUMMARY**	Yes	No
1. Pending income reported?		
2. Client questioned?		
3. Statements in doubt or inconsistent?		
4. **Spot** checks required? (If yes, enter factor(s) and date(s) in Section III.)		

III. ELIGIBILITY DETERMINATION

	YES	NO	REMARKS
A. Technical Eligibility Met? (If no, explain in REMARKS)			

B. Financial Eligibility Met?
YES. [ ]
Countable Income ..... _____
Appropriate Poverty Level MA Scale • _____
Result . . . . _____
If excess exists, explore eligibility in prior 3 months.

IV. SPOT CHECK ALERT

Member _____ Factor _____ Month _____

Member _____ Factor _____ Month _____

V. CASE DECISION AND ACTION CHECKLIST

[ ]Approval, *HA effective date _____
[ ]Continued eligible
[ ]Denial
[ ]Discontinuance, Effective date _____

Explain _____

*If less than 3 months retroactive coverage, explain.

Standard of Promptness Met? [ ]Yes [ ]No
If no, reason and method used to update application:

[ ]PAFS-116	[ ]PA-125.1	[ ]PA-3
[ ]PAFS-116, Sup. A	[ ]CS-333	[ ]MA-105
[ ]PA-13	[ICS-333.1	[ ]PAFS-2
[ ]PA-62	[ ]PA-121	[ ]SS-5
[ ]PA-30A	[ ]PA-121.1	[ ]PAFS-35
[ ]PA-31	[ ]PA-127	[ ]PA-40
[ ]PA-31A	[ ]PA-321	[ ]PA-66
[ ]PA-125 Series	[ ]PAFS-628	[ ]PAF

Explained:

[ ]MA eligibility coverage/KenPAC
[ ]Retroactive MA coverage
[ ]Medicaid is payor of last resort
[ ]Third Party Liability
[ ]Clients rights/obligations

Worker's Signature _____ Date _____

Concurred by _____ Title _____ Date _____

PA-1UP
(R. 5/91)

COMMONWEALTH OF KENTUCKY
Cabinet for Human Resources
Department for Social Insurance

APPLICATION/REINVESTIGATION FOR "U" AND "P" MEDICAL ASSISTANCE

Date _____
Place: [ ]Home [ ]Office [ ]Facility

Case No. _____
(Co.) (Prg.) (Case No.)

[ ]Foster Care
[ ]Subsidized Adoption
[ ]Child in Psychiatric Facility

[ ]Investigation [ ]New Application
[ ]Reinvestigation [ ]Reinstate within 10 Days of Disc.
[ ]Previously Received

1. Name _____
(Last) (First) (M.I.)

Alias _____
(Last) (First) (M.I.)

2. Social Security Number _____ Verified: [ ]Yes [ ]No
If No, Date SS-5 Sent _____

3. Sex: [ ]1-Male [ ]2-Female

4. Birthdate _____ Age _ _ 5. Race: [ ]4-White [ ]6-Asian, Asian American, Pac. Islander [ ]&American Indian, Alaskan Native
[ ]5-Black [ ]7-Hispanic

5. U.S. Citizen: [ ]Yes [ ]No If No, Alien Status _____ INS Document _____

[ ]Home/Facility _____ [ ]Approved [ ]Not Approved

[ ]Psy. Facility _____ [ ]Licensed [ ]Unlicensed

Admission Date _____ Physician Statement [ ]Yes [ ]No Projected Length of Stay _____
Date

Address _____
(Street) (City) (County) (State) (Zip Code) (Phone Number)

Ky. Resident: [ ]Yes [ ]No

Previous Placement _____

Responsible Agency _____ Type of Commitment _____

DSS Case Number _____ 12. Date of Removal _____ Placement _____

_____

13. Resources: Type Amount

Verification

Within Limits? [ ]Yes [ ]No, Reason

14. Unearned Income: Type Gross Monthly Amount

Verification

Total Countable Unearned

15. Earned Income. Type Monthly Gross

Verification

Total Countable Gross Earned

Work Expense Standard

Total Countable Earned

16. Medical Expenses

a. List all health insurance policies, policy numbers, type of coverage and premium(s) of child. Indicate how often premium(s) is paid and who pays the premium(s).

b. List other recognized medical expenses.

17. I certify all entries are correct and true to the best of my knowledge and belief. I understand this information will be used to determine eligibility for benefits from the Department for Social Insurance. I understand if I give false information or withhold information in order to receive assistance, I may be subject to prosecution for fraud. I understand I have the right to request a Fair Hearing before an impartial hearing officer if I am dissatisfied with any agency action. I understand that Social Security numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, wage records, unemployment insurance, and other matches as provided for under the authority of IEVS. The information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits. This information will be disclosed to other agencies only as permitted by law. I understand that in accepting Medical Assistance, I assign my rights to third party payments from any source, including hospital or health insurance policies, and am willing to cooperate with the Cabinet for Human Resources, Department for Social Insurance. I further understand that if I refuse to assign my rights to third party payments to the Cabinet for Human Resources, Department for Social Insurance, the case member will be ineligible to receive a medical card. I understand that when I obtain medical services with a Medical Assistance card issued to the case member, I am responsible for notifying the medical provider of any hospital or health insurance policies covering the case member. I agree to reimburse the Medical Assistance Program for services received which are later covered by insurance settlements or payments. I further give my consent to the Department for Social Insurance' to make any necessary contacts to verify my statements or gain additional pertinent informati.

I declare under penalty of perjury that all persons for whom application is made are U.S. citizens or are admitted under an approved alien status.

Signature Date Signed Ph. No.

Address

18. CHILD IN FOSTER CARE/SUBSIDIZED ADOPTION

Total Countable Unearned... $_____

Total Countable Earned....: $+_____

Total Countable....../... $_____

MA Scale for One..... $ -_____

Deficit/Excess ..... $_____

_____

Quarterly Excess..... $_____

[ ]Deficit, Eligible

[ ]Excess, Spend Down Determined

Quarter(s) Considered _____ to _____ to _____

19. CHILD IN PSYCHIATRIC FACILITY Psy. Facility Contacted _____ Current Patient Status [ ]Yes [ ]No

Date

Step I

1. Child's Countable Income $_____

2. Parent's Countable Income, If Appropriate..... $_____

3. Less MA Scale for Appropriate Family Size...$ -_____

$_____

4. Less Recognized Medical Expenses..... $-_____

$_____

Less Mo. Private Pay.... $-_____

No Excess. Complete Step II ..... $_____

Step II

1. Child's Gross Income..... $_____

2. Plus Excess Income of Parent(s), If Appropriate (Gross Income/Net Profit Less MA Scale For Appropriate Family Size)..... _____

3. Less Personal Needs Allowance.. $ -40

$_____

4. Less Increased Personal Needs.. $-_____

Allowance, If Appropriate..... $_____

5. Less Recognized Medical Expenses..... _____

6. Plus Third Party Payment Paid Directly To Facility For Cost of Care..... $_____

7. Child's Liability..... $_____

20. DECISION: [ ]Approved Effective _____ If less than 3 months retroactive MA coverage, explain

_____

[ ]Continued Eligible

[ ]Denied [ ]Discontinued Effective _____ Reason for negative action _____

_____

FORMS CHECKLIST:

[ ]PAFS-2 [ ]MA-105 [ ]PAFS-116 [ ]PAFS-628 [1PA-3 [ ]PA-8 [ ]PA-13 [ ]PA-31 [ ]PA-31A [ ]PA-40 [ ]PA-62 [ ]DSS-111A [ ]DSS-114 [ ]DSS-125 [ ]Commitment Documents/ Adoption Agreement I]LO1 [ ]MAP-552 [ ]SS-5 [ ]SS-10 [ ]SSA-5028

COMMENTS:

Standard of Promptness Met: [ ]Yes [ ]No, Reason _____

_____

Worker Signature _____ Date _____

Supervisor Signature _____

KIM-100
(R. 3/94)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR SOCIAL INSURANCE

J-Joint Queetion
I-IX Question
F-FS Question

KAMES-INTEGRATION APPLICATION

PART I.

(J) Aesfgned Caseload: _____ (J) Date of Application: _____ (J) Caseworker: _____

(I) Program Applying For: _____ (If State Supp or Pass Through, complete supp. 1; If Foster Care, complete Supp. K)

(I) Applying for Self? _____

(J) Case Name: _____ (J) Your SSN: _____

(J) Home Address: _____

_____

(J) City/State/Zip: _____ (J) Phone: _ _ _

If your mailing address is different from your home address, what is it?

(J) Wailing Address: _____

_____

(J) City/State/Zip: _____

(F) Does the houeahold have an authorized representative? _____

(I) If IX, is person making application different from case name, or is there a 'protective payee? _____

(If yes to either of the above questions, complete Supplement A)

(J) Is anyone in your houeehold on strike? _____ (If yee, complete a Supplement C, Part C)

(J) Are all members of your household by definition homeless? _____

(J) Is client/applicant a resident of Kentucky? _____ (J) County of Residence: _____

(J) Residency verification source: _____ (J) Date: _____

FOR: p - s - - - - - - - - -

FS applicants complete the following questions: If your household has little or no income or resources you may be able to receive food **stamps** within a few, **days. Please answer these questions to help us decide if you need food stamps** right away.

_____ How much do the members of your household have in cash and savings?

_____ What is the total **gross** income for the month for everyone in your household?

_____ **Is** anyone in your houeehold a migrant or seasonal farm worker?

_____ **If yes, is this** houeehold destitute?

_____ **Has** every member of your household been approved for or now receive **AFDC** or **SSI?**

_____ Do shelter **expenses** exceed gross income and liquid **resources?**

(**The** *FS* applicant **must** sign here if only part I **is** completed.)

The information I gave on this application is complete and true to the beet of my knowledge. I understand if I give falee information or do not report all of the information needed, I may be **subject** to prosecution **for** fraud. **I understand** that **I shall** complete an interview and provide any needed information or proof of eligibility before thie application can be approved.

Signature: _____ Date: _____

Witness if X: _____

All food stamp applications are **considered** without regard to race, color, age, **sex, disability**, religious creed, national origin or political **belief.**

You or **someone** you **choose** to represent you may **request a** fair hearing if you disagree **with any** action taken on your case *or* **feel** like you have been treated unfairly. The **hearing** can be requested by calling *or* going to the **food** stamp office or by writing a **request** and sending it to the office. At the hearing, you can be represented by anyone **you choose.**

Residents of public institutions, who apply *for* food stamps prior to their releaee from the inetitution, **shall** have eligibility for **benefits** determined beginning with the date they are released from the institution.

PART II. HOUSEHOLD LEVEL INFORMATION

A. HOUSEHOLD MEMBERS

List all people who live at this address. Enter a statue code under each program(s) requested; apply FS policy and IM standard filing unit/relative responsibility. For In, each "M" and "R" individual must have an ID Code entry.

	First Name	MI	Last Name	SSN	Mult SSN?	Birthdate	Sex	FS	IM	ID Code	From	To
(J)												
(J)												
(J)												
(J)												
(J)												

(J) Houeehold size verification source: _____ Date: _____

(J) Are there more? _ _ (If yes, complete Supp. C, Part A.) (For children and IM ID 61 in C, W, L, N, Y, I, P, or U cases, complete Supp. L.) (If any member hae a boarder, status, complete Supp. C, Part D or E.) (Complete Supp. X, if theee condition8 are met: If IM ID is 40-42, 47-50, or 60, Pg. 1; If IM ID is 43, 56-58, Pg. 2; If IM ID is 44, Pq. 3; If IM ID is 45, Pg. 4; If IM ID is 46, 51, 53-55, Pg. 5; If IM ID is 52, Pg.6.) (If FS Non-Member, complete supp. xx.)

B. APPLICATION MEMBERS - IM applicants canplete this section.

MEMBER	NAME	SSN	ID CODE	HIGHEST GRADE	LAST JOB	AVG HRS PER WEEK CODE	WIC REFERRAL

(If mote than 5 household members, complete Supplement C, Part B)

C. GENERAL HOUSEHOLD INFORMATION

Please answer the following questions about you and your household.

_____ (F) Does anyone eat in a communal dining facility?
_____ (F) Does anyone receive meals on wheels?
_____ (F) Does anyone use a food delivery service?
_____ (F) Is the household living in a certified Rehab Drug/Alcohol/Mental Health Center or a person defined as blind or disabled in an eligible group living arrangement?
_____ (F) If a group living arrangement, how many people live in this home?
_____ (F) Is anyone in your household a migrant or seasonal farmworker?
_____ (J) Does anyone in your household own a vehicle? (If yes complete Supplement E)
_____ (J) Doe8 *anyone receive income from* self employment (non-farm and non-boarder)? (If yes, complete Supp. D, Part B.)
_____ (J) Does anyone receive income from rental property? (If yes, complete Supp. D, Part B.)
_____ (J) Does anyone receive income from eelf-employment (farm income)? (If yes, complete Supp. D, Part A.)
_____ (I) If yes, have farming activities ceased?
_____ (F) Is the houeehold living in a center for'abused spouses?
_____ (I) Is the household living in an emergency shelter? (If yecsomplete Supp. F.)
(I) What banking institution(s) does your household use to cash checks?

_____ (I) Is the applicant eligibility test appropriate7
(FS Applicants must complete Supplement B.)

PART III. MEMBER LEVEL INFORMATION
GENERAL MEMBER INFORMATION

Please provide the following information for the head of the household. (If there are additional household members, complete a Supplement G. for each additional member.)

MEMBER #1: _____ _____
(SSN) (First Name) (MI) (Last Name)

_____ (J) If this person has no SSN, will this person apply for one?
(J) Date of SS-5: _____ (J) Good Cause Date: _____
_____ (J) Is it "necessary" for anyone outside of the household to be paid to take care of this person (Dependent Care, not Medical Expeneee)?
_____ (J)' What is the SSN of the member who pays for this care?
(J) Amt Paid: _____ (J)Ver Amt: _____ (J)Ver Src: _____ (J)Date: _____
_____ (I) Is dependent care valid for an IM child over the age of 127
_____ (F) Is this a joint application for SSI and food stamps?
_____ (J) Is this person providing care for a disabled person or child?
_____ (J) If yes and a child,. what is the youngest child's birthdate?
_____ (I) If yes and a disabled person, does this person live with you?
_____ (I) If yes and a child, are you the parent or other relative?
_____ (F) Is adequate child care available?
_____ (F) Is this person JOBS *or* UIB registered?
_____ (F) Is this Person verified unable to work?
_____ (F) Is this *person* in a drug addiction or alcohol treatment program?
_____ (F) Is this person working 30 hrs/wk or earnings/in-kind = 30 x min/wage?
_____ (F) Is thie person in a job/training program or exempt wk reg for medical reasons?
_____ (J) Does this person live in an ineligible facility? If yes, FS IM

SAME FOR: _____ _____ _____

It4 applicants complete the following questions:

_____ If not receiving food stamps, has this person applied?
_____ Is she pregnant? If yes, expected date of delivery? _____
How many births are expected from this pregnancy,? _____
Verif ication *Source:* _____ Datet _____
_____ Is she in her postpartum period? If *no* longer pregnant, end date: _____
_____ Was she pregnant at the time of previous termination in Kentucky?
_____ Did she move out of state? Effective month of discontinuance: _____
_____ Is this person covered by health insurance? (If yes, complete Supp.V)
_____ Is this person married? If yes, is spouse living with this person? _____
_____ Is this person potentially eligible for RSDI, Railroad Retirement, *Black* Lung, Veteran's Pension or Compensation, Workers Comp, Unemp Insurance, Veteran's Admin Improved Pension, or other pensions?
_____ If yes, has this person indicated they will apply for and comply with program requirements?
Verification Source:____ Date: _____
_____ Has this person complied with these requirements? Verif. Source: _____
Date:
_____ Is this person potentially eligible for SSI? If yes, has this person applied?
Verif Source: _____ Date: _____

SAME FOR: _____ _____ _____ _____ _____ _____

MEMBER #1: _____ _____
(SSN) (First Name) (MI) (Last Name)

IM applicants please complete the following questions:

_____ Is this person attending school? (If yes, complete Supplement Y)
_____ If child, and leaving foster care placement when will this child enter the household?
_____ Is thie person in a long term care facility, a waiver program (HCBS, AIS/MR), Hospice, or a child in an approved psychiatric facility? If yes, enter provider number(s): _____ (Complete Supp. J for each provider number entered)
_____ If the child is in an approved psychiatric facility, will the child be absent from the parents home for 30 days or more? Ver. Src: _____ Date: _____
_____ If the child is in an approved psychiatric facility, is the child in custody of DSS?
Ver. Src: _____ Date: _____
_____ Is child currently a patient7 Date facility contacted: _____
_____ If a U application, was the child previously in an X case?
_____ Is this person receiving or conditionally enrolled in Medicare Part A?
Ver. Scr:____ Date: _____
_____ Has this person lost Social Security 'due to substantial gainful activity (SGA)?
Ver. *Src:* _____ Date: _____
End date of RSDI entitlement _____ Ver. Src. _____ Date: _____

FS applicant8 please complete the following questions:

_____ 18 this person work registering? If yes, date: _____
_____ If no, does this *person* refuse to register?
_____ 18 this person an ETP volunteer? If yes, date: _____
_____ Concurrent Volunteer? Concurrent Volunteer Date: _____
_____ Is an AFDC app. pending on this member?
_____ Is this person the primary wage 'earner?
_____ Is another household member exempt from work 'reg. for caring for this member's child(ren)?
_____ Is this person potentially eligible for ETP child care?
_____ Ha8 this person quit a job? If yea, why? _____ When? _____
_____ Does this make the household ineligible?
_____ Is this person receiving AFDC? _____ Is this person receiving State Supplementation?
_____ If not, has this person been approved for AFDC or State Supplementation?
_____ I8 this person receiving SSI?
_____ In school 1/2 time or more? (High School/Job Training/ETP or TM Higher Ed = Y)
_____ Is this person enrolled in a school or course of higher education?
_____ Are tuition/fees paid for technical, vocational, correspondence school or higher education?'

(If yes to student questions above, complete Supplement Y)

MEMBER #1: _____ _____
(SSN) (First Name) (MI) (Last Name)

_____ (J) How many jobs will you be paid for in the period of" _____ to _____?
(Complete a Supp. R for each job.)

_____ (J) Doe8 this person receive unearned income? If yes, types: _____PA _____RSDI _____SSI _____UIB _____Defra Support _____VA _____Black Lung _____RR Ret _____Educ Income _____Federal Civil Service Comm Peneion _____KEOGH/IRA Peneion _____Military Pension _____State or Local Government or Private Peneion _____Insurance Peneion _____Support/Alimony. _____Friends/Relatives _____Worker.8 Comp _____Other(Intereet, Strike Pay, Land Contracts, etc.)
(Complete a Supplement S *for* the appropriate type(s) of unearned income indicated above)

_____ (I) Did thie person receive AFDC from another state this month?
_____ (J) Is this person repaying an overissuance from any source?
_____ (J) Doe8 this person receive any.Lump Sum? (If yes, complete Supp. SS)
_____ (F) Is thie member paying medical bille for an eligible non-member? (If yes, complete Supp. U)
_____ (F) Is thie member aged/blind/die&led with his/her own medical bills? (If yes, complete Supp. U)
_____ (I) Ha8 this member incurred medical expenses for the month? (If yes, complete Supp. U)
_____ (I) Number of $30 months remaining before this action.
_____ (I) Number of $30 and one-third month8 remaining before this action.
_____ (I) Number of excluded student earned income months remaining for AFDC child.
_____ (J) Doe8 this *person* have *any* excluded income? If yes, sources: - - - - -

SAME FOR: _____ _____ _____ _____ _____ _____ _____ _____

PART **IV. COMMENTS**

CASEWORKER _____ DATE _____

PART V. FS RIGHTS, RESPONSIBILITIES AND SIGNATURE

PENALTY WARNING:

Anyone in your household who intentionally breaks any of the following rules may be stopped from receiving food stamps for 6 months the first time a rule is broken, 12 month6 the second time and permanently for the third time. The person may also be fined up to $250,000, put in prison for up to 20 years or both, and subject to an additional suspension from the Food Stamp program of up to 18 months consecutive to the original suspension. The person may also be subject to being prosecuted under other applicable federal laws.

THE RULES ARE:

Do NOT give false information or hide information to get or continue to get food stamps.
Do NOT trade or sell food stamps or authorization cards.
Do NOT use food stamps to buy ineligible items, like alcoholic drinks, soap or tobacco producta.
Do NOT use someone else's food stamps or authorization cards for your household.

YOUR SIGNATURE:

I understand the questions on.this application. I have reviewed the entries made by the caseworker and certify under penalty of perjury that the information contained on my application for Food Stamps is true and correct. I uqderetand that the information I have provided on the application including the information concerning citizenship and alien status is subject to verification by Federal, State and local officials to determine if such information is true. I understand that as an applicant for food stamps, I am required to provide a social security number for everyone who lives in my home. I understand that social security numbers will be used for various state and federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to, Social Security, IRS, SSI, Wage Records, Unemployment Insurance, and other matches as provided for under the authority of IEVS. This information may be verified through collateral contacts when discrepancies are found. Information provided under IEVS, after verification, may affect eligibility for and amount of benefits. This information will be disclosed to other agencies only as permitted by law. If any part of the information on this application is incorrect, I understand that food stamp benefits may be denied and that I may be subject to the criminal prosecution rules for knowingly providing incorrect information.

Your Signature _____ Today's Date _____

All food stamp applications are considered without regard to race, color, sex, age, disability, religious creed, national origin, or political belief.

You or your representative may requeat a fair hearing either orally or in writing if you disagree with any action taken on your case. Your case may be presented at the hearing by any person you choose.

PART V. IM RIGHTS, RESPONSIBILITIES AND SIGNATURE PENALTY WARNING:

I certify that the information provided by me in this statement is correct and true, to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify etatemente and to allow for the disclosure of pertinent financial data.

I understand that the Social Security Act requires that all recipients of assistance furnish and be identified by a Social Security Number and if an individual refuses to apply for a number, that the Department cannot make a payment or provide Medical Assistance. I understand that Social Security Numbers will be used for various State and Federal matches through the Income and Eligibility Verification System (IEVS). These matches include, but are not limited to Social Security, IRS, SSI, Wage Records, Unemployment Insurance, and other matches as provided under the authority of IEVS. This information may be verified through collateral contact when discrepancies are found. Information provided under IEVS, after' verification, may affect eligibility for and amount' of benefits. This information will be disclosed to other agencies only as permitted by law.

I understand that if I receive Aid to Families with Dependent Children (AFDC) or Medical Assistance (WA) for children whose parent(s) is voluntarily absent, I am required to cooperate in child/medical support activities. If I receive AFDC I must send all support payments to the Cabinet within 10 days of receipt. Failure to forward all payments may result in the loss of AFDC benefits, and procedures for collection will be started against me. I understand that in accepting Medical Aeeietance, I assign my rights to third party payments from any source to the Cabinet for Human Resources, Department for social Insurance. Refusal to cooperate will cause the specified relative to be sanctioned. I understand that by obtaining a medical card, I am responsible for notifying., the medical provider of any hoapital or health insurance. I also agree to reimburse the Medical Assistance Program for services received which are later covered by insuranc settlements or payments.

I agree to select a doctor or clinic participating in the KenPAC Medical Assistance Program. I understand KenPAC is a part of the Kentucky Medical Assistance Program provided on a 24-hour basis and includes the following eervicee: Physician; lab fees; hospital inpatient/outpatient services; home health; nurse anesthetists; primary care centers; ambulatory surgical centere and rural health centers. I understand that I must report all changes in circumstances and income to my worker within 10 days from the day I become aware of the change.

I understand that by receiving AFDC, all members of my case are automatically registered with the Job Opportunity Basic Skills Program (JOBS), established by Congress in.1988. If required to register for job services and seek employment, I will agree to cooperate with specified responsible agencies. I understand that all information will be used in the administration of the Medicaid Program.

I declare that all persons for whom application is made are U.S. Citizens or are admitted under approved alien status. I certify under penalty of perjury, the information, including citizenship or alien status, provided by me in this statement is correct and true to the best of my knowledge and give my consent to the Department for Social Insurance to make any necessary contacts to verify my statements.

I understand that if I give false information, withhold information or fail to report changes within 10 days, I may be subject to prosecution for fraud, reduction or loss of benefits, and I may be required to repay benefits I receive.

Your Signature: _____ Today's Date: _____

Spouses Signature: _____ Today's Date: _____

Witness, if signed with an X: _____

All applications for assistance are considered without regard to race, color, sex, disability, religioue creed, national origin, or political belief. You or your representative may request a fair hearing either orally or in writing, if you disagree with any action taken in your case. Your case may be presented at the hearing by any person you choose.